

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29560**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7939**

BIRTH NO. **ED SEP 3- 1952**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY 2219	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) 12 yrs		d. STREET ADDRESS (If rural, give location) 27 2938 Dickson	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		4. DATE OF DEATH (Month) (Day) (Year) August 19 1952	
3. NAME OF DECEASED a. (First) Jack (Type or Print)		b. (Middle)	
c. (Last) Hawkins		5. SEX Male 2	
6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Yes-married	
8. DATE OF BIRTH Nov. 25, 1914		9. AGE (In years last birthday) 37	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Wm. Hawkins		13b. MOTHER'S MAIDEN NAME Priscilla Carter	
14. NAME OF HUSBAND OR WIFE Mattie Hawkins		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes #2	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mattie Hawkins, 2938 Dickson	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyperpyrexia (etiology undetermined) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) Delirium Tremens II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR		307X	
22. I hereby certify that I attended the deceased from 8-14 1952 , to 8-19 1952 , that I last saw the deceased alive on 8-18 1952 , and that death occurred at 2:05 p. m. , from the causes and on the date stated above.			
23a. SIGNATURE A. J. Irvine (Degree or title) M. D.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 8-20-52		24a. BURIAL, CREMATION, REMOVAL (Specify) removed	
24b. DATE 8-26-52		24c. NAME OF CEMETERY OR CREMATORY National Cemetery	
24d. LOCATION (City, town, or county) (State) Jefferson Barrack Mo.		DATE REC'D BY LOCAL REG. AUG 21 1952	
REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Ellis Funeral Home	
ADDRESS 2820 Stoddard		(Licensed Embalmer's Statement on Reverse Side)	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

Fulton E. Culkin

Licensed Embalmer No.

4198

P. O. Address

Albion 137

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.